Medicine: the prosperity of virtue

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Many doctors in Britain today feel under siege. They are told that the services they offer do not meet the standards demanded by the public. They are told that they are not delivering for patients. They are told that other groups can do what they do as well as they can or perhaps even better (prescribing, for example). They are told that they must embrace new providers in healthcare because that is the only way to break the restrictive practices they have been imposing for decades.[1] They are told that a new raft of medical regulation is needed to prevent the crimes of Harold Shipman and the negligence of others from happening again.

The attitude of the state towards doctors has never been more critical. It has led to panic at some medical institutions with occasionally disastrous consequences.[2,3] This dimming of the profession's flame will be welcomed by critics of professional power. But the endemic demoralisation of doctors today is creating a cold front of danger that threatens the public's health.

Professionalism is medicine's most precious commodity. Professionalism is not some old-fashioned luxury enjoyed by a privileged elite. It is central to the improvement of health. Yet professionalism is currently jeopardised by a political culture that is hostile to any source of power that is seen as competitive with government. Doctors have been largely outmanoeuvred by a far more adaptable and intelligently strategic political class. For too long they have clung to an idea of professionalism that has included ancient concepts such as autonomy, mastery, and bounded knowledge. These elements of an anachronistic professionalism are now obsolete. Doctors should see the demise of these outmoded ideas as an opportunity for redefining their purpose in a radically different era.

It was into this sea of frustration and uncertainty that the Royal College of Physicians stepped last year when it established a working party on medical professionalism. After more than a year of work, its report, conclusions, and recommendations are published this week (panel 1).[4,5] The central task of the working party was to define the meaning of medical professionalism in a health system that is almost unrecognisable from a generation ago (panel 2).

At the heart of professionalism lies the notion of uncertainty. A doctor's daily practice is marked by judgment in the face of often intense unpredictability. A doctor's knowledge and experience form the basis for such judgments. But herein lies a weakness. Because so much of medical practice calls for wisdom as well as technical skill, doctors are exposed to the charge—now frequently made—that their decisions lack transparency and accountability. The clear pressure on doctors today, a pressure that some of their leaders have buckled under, is

Panel 1: The Royal College of Physicians Working Party on Medical Professionalism

The working party was launched in 2004 with the aim of defining the nature and role of medical professionalism in modern society. In a departure from tradition, its chairperson —Baroness Julia Cumberlege, a former UK health minister— was appointed from outside the College. The evidence gathered by the working party included a systematic review of the literature on medical professionalism, the results of a survey of over 2000 UK medical trainees, written evidence from over 100 witnesses, oral evidence from 20 witnesses, the results of focus groups, and consultations with lay, medical, nursing, and allied professional organisations.

Panel 2: A new definition and description of medical professionalism[4]

Definition

Medical professionalism signifies a set of values, behaviours and relationships that underpins the trust the public has in doctors.

Description

Medicine is a vocation in which a doctor's knowledge, clinical skills, and judgment are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability.

In their day-to-day practice, doctors are committed to:

- integrity
- compassion
- altruism
- continuous improvement
- excellence
- working in partnership with members of the wider healthcare team.

These values, which underpin the science and practice of medicine, form the basis for a moral contract between the medical profession and society. Each party has a duty to work to strengthen the system of healthcare on which our collective human dignity depends.

to explain what they do robustly and confidently, and to describe how and why they do it.

A redefinition of professionalism is not a pointless matter of semantics. Research by the Picker Institute, an organisation that promotes patient needs, has found that half of hospital patients want more involvement in clinical decisions about their care.[6] The Healthcare Commission found that a third of patients receive conflicting information from health professionals.[7] What we mean by professionalism matters a great deal. Patients know when professionalism falls short of what they expect.

The idea of professionalism pervades much of modern health policy and practice, but in utterly ill-defined ways. The word "professionalism" is, for example, sprinkled liberally throughout the documents that describe Modernising Medical Careers. The assessment tools used for the foundation years of practice after graduation recognise the importance of professional relationships, but without defining what constitutes professionalism. When a measurement instrument uses the phrase "consistently behaves with a high degree of professionalism", what does that mean? Neither the doctor being assessed nor the assessor is enlightened. This imprecision is at best complacent, at worst dangerous.

For the **BMA report on professional values** see http://www.bma.org

The assumption is that the meaning of medical professionalism lies in the General Medical Council's *Good Medical Practice*. It does not. *Good Medical Practice* is a seriously deficient document, and it is likely to continue to be so even though it is currently undergoing revision. *Good Medical Practice* sets out the duties that a doctor must discharge. Those duties are rules that are linked to punishment (removal from the medical register) if they are broken or breached. The word "professionalism" appears throughout *Good Medical Practice* as a comforting adjective. It lends support to words such as "competence" and "knowledge". But the notion of professionalism itself is ignored. The listed duties are not put in the context of a rigorously worked out view of what medical professionalism means. Put simply, the GMC has missed the significance of professionalism. This lapse is currently proving damaging to the credibility of the organisation.

The same confusion afflicts appraisal. The chaos that is modern health-care regulation has left the profession in disarray. The political consensus is that doctors do not set sufficiently high standards of practice; that even when they do, they fail to act when those standards are not met; and that the profession has shown itself to be insufficiently concerned about protecting patients. The result is inquiry after inquiry, law after law, to bring doctors to heel, to make them more "accountable".

Yet there remains no agreement about the purpose of either medical regulation or accountability. Some believe that regulation can only stop bad things from happening. Others believe that it can make good things happen. Each view, entirely contradictory in its implications, was put with vigour at a recent King's Fund seminar on regulation by Lord Haskins (who formerly led the UK government's Better Regulation Task Force) and Ian Kennedy (chairman of the Healthcare Commission), respectively. This vagueness is reflected in the detail of the appraisal process for every doctor in the National Health Service (NHS). Despite paying lip-service to professionalism, nowhere does appraisal focus specifically on what professionalism means—an astonishing omission.

This systemic refusal by major medical institutions in Britain to address medical professionalism goes a long way to explain the most alarming finding of a recent report on professional values published by the British Medical Association. In a survey of UK doctors who graduated in 1995, the proportion who saw medicine as just a job like any other rose from 1·9% in 1995 to 8·5% in 2004. The belief in medicine as a vocation may slowly be ebbing away in the face of a sustained assault on doctors by an ever more aggressive state and media. Four out of five doctors believe that the public's expectation of what they can reasonably deliver is too high. The state is killing the motivation of too many doctors.

An understanding of medical professionalism sits at the centre of today's conflicts over the future of Britain's health system. It lies at the heart of much disquiet over the government's vision for a "patient-led NHS", a slogan in desperate search for a meaning. The implications of the working party's definition and description are potentially broad and significant, affecting medicine's leadership, clinical teams, education, appraisal, careers, and research (panel 3).

Clinical *leadership* in the NHS is weakened and diluted by the complexity of often competing medical institutions. Unified and upgraded leadership, together with strengthened management skills, are vital if doctors are to defend successfully patient and public interests alike. The working party calls for the creation of a new "common forum" for medicine, through which it could speak with a single voice.

Strong clinical *teams* are essential for the effective delivery of medical care. Much evidence indicates that clinical teams underperform in today's health service. Doctors need to be better supported in their contributions to multiprofessional teams. Joint learning through interprofessional education and training may be one way to do so.

Education has a neglected place in strengthening an ethos of patient-centred professionalism. From student selection to medical training, from ethnic and cultural diversity to mentorship, the contribution of education to modern notions of professionalism needs to be re-evaluated.

A good system of *appraisal* is a foundation stone for sustainable medical professionalism. But appraisal today is not fit-for-purpose. The professional content of appraisal is negligible. It needs to be increased and incorporated into the evaluation of a doctor's performance and development. The management of a medical *career* must be flexible and adaptable enough to accommodate the dramatic demographic changes taking place in the medical workforce today, yet robust enough to embed within it a system-wide commitment to sustain patient-centred professionalism. Finally, *research* into medical professionalism is essential for augmenting a concept that is tied inextricably to better patient experiences and improved health outcomes.

The working party's recommendations have far-reaching implications for medical institutions in Britain today—the GMC, the Academy of Medical Royal Colleges, the Department of Health, the British Medical Association, medical schools, and research funding bodies. Britain's health system needs mechanisms to incentivise policy makers, employers, and managers to value professionalism as an important lever for improving the quality of services to patients.

Medical regulation has swung too far in favour of tightly enforced rules devised in a culture of suspicion about doctors. This punitive system needs to be balanced by an emphasis on a doctor's natural desire to promote positive patient outcomes compassionately, altruistically, and scientifically. The report from the Royal College of Physicians should be the beginning of a movement to initiate public dialogue about the role of the doctor in creating a healthier and fairer society. Medical professionalism needs to be put back onto the political map of health.

Panel 3: Selected recommendations from the working party

The working party recommends that:

- Doctors assess their values, behaviours, and relationships against the working party's description, and that they take personal responsibility for ensuring that this aspirational standard of modern professionalism is met in their daily practice.
- Royal Colleges and Faculties, medical schools, the British Medical Association, and other healthcare organisations, take on the responsibility to develop a cadre of clinical leaders. These bodies need to define the skills of leadership that they seek, and implement education and training programmes to develop doctors with those skills.
- The Royal College of Physicians, working with others, creates an implementation group to define the requirements for a common forum, the purpose of which would be to speak on behalf of medicine with a unified voice.
- The General Medical Council, other regulatory bodies, and medical schools explore ways of strengthening common learning to enable better interprofessional education and training.
- Medical schools consider introducing professional values early into the undergraduate medical course by means of a ceremony at which students would pledge their commitment to those values publicly. This event would be akin to the 'white coat ceremony' practised by many American medical schools.
- The Academy of Medical Royal Colleges considers the issue of mentorship in a doctor's training and, building on existing programmes, reviews the potential value of a national mentorship programme to provide a means for the sustainable transmission of professional values.
- The Department of Health, in conjunction with the Academy of Medical Royal Colleges, the General Medical Council, and the British Medical Association, begins a review of the professional content of appraisal, with a view to incorporating professional values as key components in evaluating a doctor's performance and development..

A complete list of the working party's recommendations can be found in the full report.[4]

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The working party was initiated by the President of the Royal College of Physicians, Dame Carol Black, and was chaired by Baroness Julia Cumberlege. Its members included: Carol Black (Royal College of Physicians), Niall Dickson (King's Fund), William Doe (University of Birmingham), Ahmed Elsharkawy (Southampton University), Mike Hayward (Royal College of Nursing), Sean Hilton (St George's Hospital Medical School), Richard Horton (*The Lancet*), James Johnson (British Medical Association), Gill Morgan (NHS Confederation), Roger Neighbour (Royal College of General Practitioners), Bob Nicholls (General Medical Council). Roy Pounder (University of London), Trudie Roberts (University of Leeds), David Scott (Norfolk and Norwich University Hospital), Ray Tallis (University of Manchester), Claire Walmsley (RCP Patient and Carer Involvement Steering Group), and Valerie Wass (University of Manchester). Susan Shepherd (Royal College of Physicians) was Secretary to the working party. I wrote and revised the final report.

1 Hattersley R. Ordering the doctors. *Guardian*, Nov 14, 2005: 31.
2 Horton R. A dismal and dangerous verdict against Roy Meadow. *Lancet* 2005; **366:** 277–78.
3 Editorial. The NHS: a national health sham. *Lancet* 2005; **366:** 1239.
4 Royal College of Physicians. Doctors in society: medical professionalism in a changing world. London: RCP, 2005.
5 Royal College of Physicians. Doctors in society: medical professionalism in a changing world. Technical supplement to a report of a working party of the Royal College of Physicians of London. London: RCP, 2005.
6 Picker Institute Europe. Is the NHS getting better or worse? Oxford: Picker Institute Europe, 2005.
7 Healthcare Commission. State of healthcare 2005. London: Commission for Healthcare Audit and Inspection, 2005.